MARICOPA MANAGED CARE SYSTEMS
PROTOCOL

SUBJECT: Circumcision, Male APPLIES TO: MHP ☒ MLTCP ☒ MSSP ☒ HEALTHSELECT ☒	Protocol #: PA P149.01 Total Pages: 1 Attachments: Yes ☐ No ☒ Initial Effective Date: June 1999 Latest Review Date: 11/2002 This protocol will be reviewed annually.

MMCS APPROVALS:

Operations Director:_____ Date:_____

Medical Director:_____Date:_____

PURPOSE: The purpose of this protocol is to state the Prior Authorization Criteria that the Medical Management Department will use as it pertains to **medically necessary** Circumcision, Male.

PROTOCOL:

A. Circumcision, Male
ICD9: 54150 - 54161
LOS: OP

B. The prior-authorization specialist may approve if **any** of the following are met:
1. If there is a documented history of recurrent (after two (2) attempts at traditional treatment) balanitis and/or phimosis

2. Recurrent urinary tract infections in a male child related to foreskin problems

C. This criteria is a guideline for prior authorization and does not represent a standard of practice or care.

D. This protocol addresses medical coverage issues only and does not review individual benefit coverage issues. In order to issue an authorization number, the procedure must meet medical guidelines and benefit coverage guidelines under the specific plan.

E. If requirements are not met, Medical Director review is required.